

PAC Bundling: a policy option for generating significant sustainable program savings while securing beneficiaries' access to the care they need in the most cost-effective setting available.

Proposed Model: clinical condition-specific, site-neutral, bundled payment model for PAC services

- **Episode:** 90-days beginning on the date of a patient's discharge, contingent on a physician's order for PAC as well as acceptance of the patient's admission for PAC services.
- **Convener:** bundle to be managed by a risk-bearing convener (which could be any of the following: hospitals, insurers, third-party benefits managers, or PAC providers, per below), which would establish a provider network and manage patient assignment, care coordination, and provider reimbursement under the bundle.
 - Conveners to be certified as meeting key criteria and governance standards, such as credit-worthiness, and form an advisory board of PAC provider and patient stakeholders (per ACOs) for internal oversight.
- **Structure:** clinical condition-specific bundles with site-neutral pricing and benefits coverage and a scope encompassing PAC and outpatient physical therapy services related to the care received by the patient in the hospital but excluding index hospital care and physician, hospice, outpatient, and ambulance services.
- **Readmissions:** valuation of each bundle to include cost of readmissions related to the care provided under the bundle, with PAC conveners and providers at risk for any hospital readmission and post-discharge care within the 90-day episode. If none, the discharging hospital(s) would be credited.
- **Reimbursement:** PAC providers to be paid under existing FFS codes (to foster predictability and expedite implementation); PAC-managing physicians to be paid by CMS using either a new Transitional Care Management (TCM) code or expanded use of existing TCM codes 99495 and 99494.
- **Shared Savings and Risk:** risk and gain to be assumed and managed by the convener: if a patient's total cost exceeds the bundle amount, convener assumes the risk; if total cost is less than the bundle amount, the savings (or gain) would be distributed as follows (with actual shares to be set at the convener's discretion):
 - Convener: not more than 70%; PAC Provider Network: not less than 10% (with distribution determined by convener); PAC-managing physician(s): not less than 10%; discharging hospital(s): not less than 10%.
 - Convener authorized to use shared savings, prior to distribution, to provide supplemental payments to providers for services or investments that improve quality improvement and cost reduction.
- **Safeguards:** conveners to be subject to new safe harbor for PAC, a risk corridor against excessive downside risk, and network adequacy rules requiring them to meet a specified standard for contracting with PAC providers and, if necessary, authorizing them to contract with providers outside the immediate region.
- **Innovation:** providers authorized to offer (directly or via contract) services that will contribute to patient care, safety, and readmission avoidance, including but not limited to: medication management, telehealth technologies, home environment services, transportation services, and durable medical equipment.
- **Patient and Provider Eligibility:** all current standards to be retained, with restrictive vestiges of current PAC 'silos' including eligibility criteria lifted and Conditions of Participation modified to ensure seamless care criteria for providers and conveners.
- **Choice:** patient freedom to choose a convener and, thus, the convener's contracted providers as well as the freedom to choose any provider that is available within the convener's contracted network; each patient's PAC-managing physician would also free to choose from among the providers that are available through the convener.
- **Patient Assessment:** a common patient assessment tool for all providers to be utilized, such as a condensed version of the Continuity Assessment Record and Evaluation (CARE) tool, provided it is adjusted from the tested version in order to improve ease of use on the part of providers.
- **Quality Improvement:** a Quality Improvement Program (QIP) to potentially be included, funded by a withhold and used for performance bonus payments to those conveners meeting the QIP's specified criteria.
- **Savings:** Congressional directive to the Secretary that total Medicare PAC payments under the bundle not exceed a specified percentage of baseline spending (defined as all current Medicare PAC and OPT spending and applicable readmissions). CACEP modeling suggests \$100 billion over 10 years may be feasible at 92.5% of current baseline.

- Implementation: a structured implementation process spanning four years to be utilized as per such transitions as the initial Inpatient Prospective Payment System (“IPPS”) and the dialysis bundle; initial focus on MS-DRG 470 conditions may be a suitable first step.